cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under subsection (d).

(d) Each provider shall submit, upon request, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.

(e) If a provider has business enterprises or activities other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises or activities shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field or desk audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs.

(f) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report coincidental with the time period for any individual facility that

receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improve efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient-related lies with the provider.

405 IAC 1-14.6-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established,

audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arms-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data.

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient-related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the

best of the preparer's knowledge.

(d) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office. Any extension granted under this section may not exceed an additional ninety (90) days, for a total of one hundred eighty (180) days after the close of the provider's reporting year.

(e) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost

because of the penalty cannot be recovered by the provider.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information to the office or its contractor in a complete, accurate, and timely manner.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment, or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

(1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or transfer to hospital.

(2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or transfer to hospital.

(3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has transmitted incomplete MDS resident assessments, then for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC1 - Unclassifiable."

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then for purposes of determining the facility's CMI, such assessment(s) shall be assigned the case mix index associated with the RUG-III group "BC2 - Delinquent."

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has

untimely MDS resident assessments, then such assessment(s) shall be counted as an error for purposes of determining whether a corrective remedy shall be applied under subsection (k).

(k) If the office or its contractor determines due to an MDS field audit that a nursing facility has inaccurate MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

(1) The office or its contractor shall audit a sample of MDS resident assessments, and will determine the percent of assessments in the sample that are inaccurate or untimely.

(2) If the percent of assessments in the sample that are inaccurate or untimely is greater than the threshold percent as shown in column B of the table below, the office or its contractor shall expand the scope of the MDS audit to all residents. If the percent of assessments in the sample that are inaccurate or untimely is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the MDS audit and no corrective remedy shall be applied.

(3) For nursing facilities with MDS audits performed on all residents, the office or its contractor will determine the percent of assessments audited that are inaccurate or untimely.

(4) If the percent of assessments of all residents that are inaccurate or untimely is greater than the threshold percent as shown in Column B of the table below, a corrective remedy shall apply, which shall be calculated as follows. The administrative component portion of the

Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in column (C) of the table below. In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs. Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.

(5) If the percent of assessments of all residents that are inaccurate or untimely is equal to or less than the threshold percent as shown in column (B) of the table below, the office or its contractor shall conclude the audit and no corrective remedy shall apply.

(6) The threshold percent and the administrative component corrective remedy percent in columns (B) and (C) of the table below, respectively, shall be applied to audits begun by the office or its contractor on or after the effective date as stated in column (A) of the table below.

Effective Date	Threshold Percent	Administrative Component Corrective Remedy Percent
(A)	(B)	(C)
October 1, 1999	50%	5%
January 1, 2001	35%	10%
April 1, 2002	20%	15%

(1) Based on findings from the MDS audit, beginning on the effective date of this rule, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(m) Beginning on the effective date of this rule, upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made.

405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial

interim rates

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, indirect care, administrative and capital components. Prior to the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second quarters of operation, in the provider's case mix index for Medicaid residents and adjusted prospectively after the second quarter to reflect changes in the provider's case mix index for Medicaid residents. Initial interim rates shall be effective on the certification date or the date that a service is established, whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this rule shall apply.

(b) Prior to the first annual rate review, the rate will be adjusted effective on each calendar quarter pursuant to section 6(d) of this rule to account for changes in the provider's case mix index for Medicaid residents. The first annual rate review shall coincide with the provider's first fiscal year end that occurs after the initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.